

## **Medical Assistance Administration**



# **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program**

(WAC 388-534-0100)

## **Billing Instructions**

**July 2001**

## **Copyright Disclosure**

*Current Procedural Terminology (CPT) five digit codes, descriptions, and other data only are copyright 2000 American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein.*

## **About this publication**

**This publication supersedes all previous MAA EPSDT Billing Instructions.**

Published by the Medical Assistance Administration  
Washington State Department of Social and Health Services  
July 2001

**Received too many billing instructions?  
Too few?**

**Address Incorrect?**

Please detach, fill out and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

# Table of Contents

---

<b>Important Contacts</b> .....	iii
<b>Definitions</b> .....	iv
 <b>Section A: About the Program</b>	
What is the purpose of the EPSDT program? .....	A.1
Who can provide EPSDT screenings? .....	A.1
 <b>Section B: Client Eligibility</b>	
Who is eligible for EPSDT screenings? .....	B.1
Are clients who are enrolled in a Healthy Options managed care plan eligible for EPSDT services? .....	B.2
Primary Care Case Manager/Management (PCCM) .....	B.2
 <b>Section C: EPSDT Screening Components</b>	
What are EPSDT screenings? .....	C.1
What is included in an EPSDT screening? .....	C.1
How often should EPSDT screenings occur? .....	C.2
What are EPSDT interperiodic screenings? .....	C.3
What are the time limits for scheduling requests for EPSDT screenings?....	C.3
What if a medical problem is identified during an EPSDT screening examination? .....	C.4
Referrals	
Medical Nutritional Therapy .....	C.4
Chiropractic Services .....	C.4
Dental Services .....	C.4
Orthodontics .....	C.4
Lead Toxicity Screening .....	C.5
Fetal Alcohol Syndrome (FAS) Screening .....	C.5
Washington State FAS Clinic Locations .....	C.6



**Table of Contents continued...**

## Table of Contents...(cont.)

### Section D: Mental Health/Substance Abuse Assessment

Mental Health .....	D.1
Screening Guidelines .....	D.1
Non-Urgent Referral .....	D.2
Urgent Referral .....	D.3
Substance Abuse .....	D.3
Information and Referral .....	D.4
Referral for Mental Health/Substance Abuse Assessment Form (DSHS 01-192X) .....	D.5
Reorder Information .....	D.6
EPSDT Mental Health/Substance Abuse Assessment Referral Indicators ...	D.7
Washington State Regional Support Networks (RSNs) .....	D.8
Referral Explanation for Teen and/or Parent .....	D.9

### Section E: Billing

What is the time limit for billing? .....	E.1
How do I bill for services provided to PCCM clients? .....	E.2
Third party liability .....	E.3

#### Fee Schedule

EPSDT Screenings .....	E.4
New Patient .....	E.4
Established Patient .....	E.5
Interperiodic Screening .....	E.5
Laboratory Services .....	E.5
Handling Fees .....	E.6
Administration of Immunization .....	E.6
Immunizations .....	E.6
Administration of Immune Globulin .....	E.10
Immune Globulins .....	E.10
Audiologic Function Tests .....	E.10
Fluoride Varnish Applications .....	E.11

### Section F: How to Complete the HCFA-1500 Claim Form

Guidelines/Instructions .....	F.1
Sample HCFA-1500 Claim Form .....	F.5

### Appendix A: Infant Toddler Early Intervention Services

# Important Contacts

---

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.

[WAC 388-502-0020(2)]

**Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?**

**Call the toll-free line:**  
(866) 545-0544

**Where do I send my claims?**

**Hard Copy Claims:**

Division of Program Support  
PO Box 9248  
Olympia WA 98507-9248

**Magnetic Tapes/Floppy Disks:**

Division of Program Support  
Claims Control  
PO Box 45560  
Olympia, WA 98504-5560

**Electronic billing?**

Electronic Billing Unit  
PO Box 45512  
Olympia, WA 98504-5512  
(360) 725-1267

**How do I request prior authorization?**

*Submit your request in writing to:*

Div of Health Services Quality Support  
PO Box 45506  
Olympia WA 98504-5506  
Fax: (360) 586-2262

**Who do I contact if I have questions on...**

**Policy, payments, denials, or general questions regarding claims processing, Healthy Options?**

Provider Relations Unit  
(800) 562-6188

**Private insurance or third party liability, other than Healthy Options?**

Division of Client Support  
Coordination of Benefits Section  
PO Box 45565  
Olympia, WA 98504-5565  
(800) 562-6136

**Access Issues, Broker Transportation, Client Complaints, Healthy Options Enrollment, Disenrollment, Exemptions?**

Medical Assistance Customer Service Center (MACSC)  
(800) 562-3022 **Clients Only**

**How can I get copies of billing instructions or numbered memoranda?**

**Check out our web site**

<http://maa.dshs.wa.gov>,  
go to the Billing Instructions link.

**Or write/call:**

Provider Relations Unit  
PO Box 45562  
Olympia, WA 98504-5562  
(800) 562-6188

# Definitions

The section defines terms and acronyms used in this booklet.

**Basic Health Plus** – A program jointly managed by the Health Care Authority and the Medical Assistance Administration. Parents can obtain coverage under Basic Health (BH) while their children can be enrolled in the BH Plus program. BH Plus offers children the expanded benefits available in the Healthy Options/MAA benefit package. This allows BH families to remain together in the same managed health care plan. *(Not to be confused with Basic Health which is sponsored by the Health Care Authority, not MAA.)*

**Children’s Health Program** - The Children’s Health Program is the state-funded program for children under age 18 who are not eligible for Medicaid. *(Not to be confused with the Children’s Health Insurance Program – CHIP.)*

**Children’s Health Insurance Program (CHIP)** - A federal/state program that covers children under 19 years of age in families whose income is too high for Medicaid, but is from 200 to 250% of the Federal Poverty Level. *(Not to be confused with the Children’s Health Program.)*

**Client** - An applicant for, or recipient of, DSHS medical care programs.

**Code of Federal Regulations (CFR)** - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

**Community Services Office (CSO)** - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

**Core Provider Agreement** - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

**Department** - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** - A program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program. [WAC 388-500-0005]

**Explanation of Benefits (EOB)** - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

**Maximum Allowable** - The maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

**Medicaid** - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

**Medical Assistance Administration**

**(MAA)** - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

**Medical Assistance Identification**

**(MAID) card** – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards or medical coupons.

**Medically Necessary** - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

**Medical Nutrition Therapy** - A direct interaction between the certified dietitian and the client and/or client's guardian for the purpose of evaluating and making recommendations regarding the client's nutritional status.

**Patient Identification Code (PIC)** - An alphanumeric code as listed on the client's MAID card that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

**Primary Care Case Management (PCCM)**

The health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services [WAC 388-538-050]

**Provider or Provider of Service** - An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department. [WAC 388-500-0005]

**Remittance and Status Report (RA)** - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration [DSHS] that provides detailed information concerning submitted claims and other financial transactions.

**Revised Code of Washington (RCW)** - Washington State laws.

**Title XIX** - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

**Title XXI** - The portion of the federal Social Security Act that authorizes grants to states for the Children's Health Insurance Program (CHIP). (WAC 388-538-0006)

**Usual & Customary Fee** - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

- 1) The usual and customary charge that you bill the general public for the same services; or
- 2) If the general public is not served, the rate normally offered to other contractors for the same services.

**Washington Administrative Code (WAC)**  
- Codified rules of the state of Washington.



# About the Program

---

## What is the purpose of the EPSDT program?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federal preventive health care benefit. The purpose of this program is to screen clients **20 years of age and younger** in order to identify physical and/or mental defects. If a physical or mental defect is identified, the client should be treated or referred to an appropriate provider for treatment. EPSDT is designed to encourage continuing access to health care.

Access to and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B.

Services, treatment, or other measures must be:

- Medically necessary;
- Safe and effective; and
- Not experimental.

## Who can provide EPSDT screenings?

- Physicians
- Advanced Registered Nurse Practitioners (ARNPs);
- Physician Assistants (PAs);
- Nurses specially trained through the Department of Health; and
- Registered nurses working under the guidance of a physician or ARNP may also do EPSDT screenings. However, only physicians, PAs and ARNPs can diagnose and treat problems found in a screening.

**This is a blank page.**

# Client Eligibility

---

## Who is eligible for EPSDT screenings?

MAA covers EPSDT screenings for clients who:

- Are 20 years of age and younger; and
- Present a Medical Assistance IDentification (MAID) card with one of the following identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP Children's Health	CNP - Children's Health Program
CNP - CHIP	CNP - Children's Health Insurance Program
CNP – Emergency Medical Only	CNP – Emergency Medical Only <i>(Covered only when the service is related to the emergent conditions.)</i>
LCP-MNP	Limited Casualty Program – Medically Needy Program



**Note:** Please refer clients to their local Community Services Office (CSO) if they are 20 years of age and younger and their MAID card does not list one of the above medical program identifiers. The CSO will evaluate these clients for a possible change in their Medical Assistance program that would enable them to receive EPSDT screenings.

## Are clients who are enrolled in a Healthy Options managed care plan eligible for EPSDT?

**Yes!** EPSDT screenings are included in the scope of service under the Healthy Options managed care program. Clients who are enrolled in one of MAA's Healthy Options managed care plans will have an identifier in the HMO column on their MAID cards.

Please refer Healthy Options managed care clients to their respective health care plan for necessary preventive health care services and medical treatments, including EPSDT services. Clients can contact their plan by calling the telephone number indicated on their MAID card.

**Do not bill MAA for EPSDT services as they are included in the Healthy Options managed health care plan's reimbursement rate.**

**Exception:** MAA covers referrals for a mental health or substance abuse assessment outside the Healthy Options managed care plan. These referrals are paid separately on a fee-for-service basis. Bill MAA directly for these types of referrals.

### Primary Care Case Manager/Management (PCCM):

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain or be referred for services via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's MAID card for the PCCM. (See Section E – Billing for further information.)



**Note:** To prevent billing denials, please check the client's MAID card prior to scheduling services and at the time of the service to make sure proper authorization or referral is obtain from the PCCM.

---

# EPSDT Screening Components

---

## What are EPSDT screenings?

EPSDT screenings are defined by federal rules as "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth" that are provided as part of a health supervision program.

## What is included in an EPSDT screening?

As a minimum, EPSDT screenings must include, but are not limited to:

- A comprehensive health and developmental history, updated at each screening examination;
- A comprehensive, **unclothed** physical examination performed at each screening examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Developmental assessment;
- Nutritional assessment;
- Appropriate laboratory tests;
- Dental/oral health assessment; including:
  - ✓ How to clean teeth as they erupt.
  - ✓ How to prevent baby bottle tooth decay.
  - ✓ How to look for dental disease.
  - ✓ Information on how dental disease is contracted.
  - ✓ Preventive sealant.
  - ✓ Apply fluoride varnish, when appropriate.
- Health education and counseling; and
- Age appropriate mental health and substance abuse screening (see page D.1).

These components may be performed separately by licensed providers; however, MAA encourages the primary care provider to perform as many of the components as possible to provide a comprehensive picture of the client's health.

## Additional Screening Components:

The following screening component services can be billed in addition to the screening codes for fee-for-service clients by using procedure codes published in these billing instructions.

- ✓ Appropriate audiometric tests (CPT codes 92552, 92553);
- ✓ Appropriate laboratory tests, including testing for anemia;
- ✓ Appropriate testing for blood lead poisoning in children in high-risk environments (CPT codes 82135, 83655, 84202, 84203).

## How often should EPSDT screenings occur?

The following is Washington State's schedule for health screening visits:

1. Five total screenings during the first year of the child's life. Below is a recommended screening schedule for children from birth to one year of age.
  - 1<sup>st</sup> Screening: Birth to 6 weeks old
  - 2<sup>nd</sup> Screening: 2 to 3 months old
  - 3<sup>rd</sup> Screening: 4 to 5 months old
  - 4<sup>th</sup> Screening: 6 to 7 months old
  - 5<sup>th</sup> Screening: 9 to 11 months old
2. Three screening examinations are required between the ages of 1 and 2 years.
3. One screening examination is required per 12-month period for children ages 2 through 6.
4. One screening examination is required per 24-month period for children age 7 through 20, except foster care children and youth who receive a screening examination every 12 months.

This schedule is the minimum required. You may use your own schedule recommended by your professional association if it includes at least the numbers stated above.

## What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

If an EPSDT screening is requested through...	For clients who are...	Must be scheduled within...
Managed Care plans or Primary Care Providers (PCPs)	Infants - within the first 2 years of life.	Within 21 days of request
	Children - two years and older.	Within six weeks of request.
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	0 through 20 years of age	Within 14 days of the request.
Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.		

## EPSDT Interperiodic Screenings

EPSDT providers can bill an evaluation and management (E&M) procedure code (CPT codes 99201-99215) **with the modifier -EP** to identify suspected health problems if regular screenings have already been conducted for the year. Use the ICD diagnosis code that most accurately reflects the reason for the client's visit.

**Modifier -EP:** Services provided as part of Medicaid EPSDT program

In addition, when an immunization is the only service performed, and the vaccine **is not** available free of charge from the Department of Health (DOH), the provider may bill a CPT immunization administration code in addition to the vaccine drug code. If the vaccine **is** available free of charge from DOH, the provider must bill MAA the vaccine drug code with the modifier -SL. MAA will reimburse the provider an administration fee.

**NOTE:** If the provider is using the mother's PIC code to bill E&M codes 99201-99215 for an infant who has not yet been assigned a PIC code, the provider **must use modifier -HA** in order to be reimbursed the higher rate for children's services. **Modifier -HA must be the FIRST modifier following the CPT or HCPCS code.** Any additional modifier may be listed second.

## What if a medical problem is identified during a screening examination?

If a medical problem is identified during a screening examination, the provider may:

- Provide the service for the client (if it is within the provider's scope of practice); or
- Refer the client to an appropriate provider for medical treatment.

## Referrals

### Medical Nutrition Therapy

(formerly known as "Nutritional Counseling")

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

### Chiropractic Services

Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

### Dental Services

Eligible clients may go to a dental provider without an EPSDT screen or referral. You should inform the client or the client's parent(s) or guardian(s) of the importance of oral/dental health and recommend that the client be seen by a dentist as follows:

- Yearly, or sooner if a problem is suspected.

**Note:** Unless a problem is suspected earlier, the child should be at least 1 year of age and have his/her first tooth and has not been examined by a dentist within the past year.

### Orthodontics

Eligible clients may go to an orthodontic provider without an EPSDT screen or referral. MAA covers orthodontics for children with cleft lip or palates or severe handicapping malocclusions only. You must obtain prior authorization from MAA before providing orthodontic services. MAA does not cover orthodontic treatment for other conditions.



## **Lead Toxicity Screening**

Providers are no longer required to use the Lead Toxicity Screening Risk Factor questionnaire. Health care providers should use clinical judgement when screening for lead toxicity.

## **Fetal Alcohol Syndrome (FAS) Screening**

FAS is a permanent birth defect syndrome caused by the mother's consumption of alcohol during pregnancy. FAS is characterized by cognitive/behavioral dysfunction caused by structural and/or chemical alterations of the brain, a unique cluster of minor facial anomalies, and is often accompanied by growth deficiency.

As part of the EPSDT screen every child six months of age and older should be screened for risk of exposure to maternal consumption of alcohol and for the facial characteristics of FAS. Children for whom there is known in utero exposure and for whom there is suspicion of facial characteristics of FAS and/or microcephaly can be referred to a diagnostic clinic.

**See next page for a list of clinic locations.**

**Washington State  
Fetal Alcohol Syndrome (FAS)  
Clinic Locations**

**King County (Univ. of WA)**

**Who to Contact:**

Susan Astely, Ph.D. or  
Sterling Clarren, M.D. Co-Directors  
Children's Hospital and Regional Medical Center  
4800 Sand Point Way NE, CH-47  
Seattle, WA 98105  
(206) 526-2522  
<http://depts.washington.edu/fasdpn/wasites.html>  
(206) 527-3959 FAX

**Clinic Location:**

FAS DPN Clinic  
Center on Human Development and Disability  
University of Washington  
Seattle, WA 98195

**South King County (Federal Way)**

**Who to Contact:**

Donna Borgford-Parnell, RN, BSN, MBA  
(206) 296-7412  
(206) 296-4679 FAX

**Clinic Location:**

FAS DPN Clinic  
Federal Way Public Health Clinic  
Seattle King County Department of Health  
999 – 3<sup>rd</sup> Avenue, Suite 900  
Seattle, WA 98104  
[Donna.Borgford-Parnell@metrokc.gov](mailto:Donna.Borgford-Parnell@metrokc.gov)

**Snohomish County (Everett)**

**Who to Contact:**

Christie Conners, Clinic Coordinator  
(425) 870-4749  
(425) 513-0917 FAX

**Clinic Location:**

FAS DPN Clinic  
Little Red Schoolhouse  
14 E. Casino Rd.  
Everett, WA 98208

**Spokane County (Spokane)**

**Who to Contact:**

Teryl MacDonald, Clinic Coordinator  
(509) 624-5858 ext. 22  
(509) 624-9995 FAX

**Clinic Location:**

FAS DPN Clinic  
New Horizons  
504 E. 2<sup>nd</sup> Avenue  
Spokane, WA 99202  
[tmacdonald@srhd.org](mailto:tmacdonald@srhd.org)  
[www.spokanecounty.org/health/sms](http://www.spokanecounty.org/health/sms)

**Yakima County (Yakima)**

**Who to Contact:**

JoAnn Jennings, RN, Clinic Coordinator  
(509) 574-3260  
(509) 574-3210 FAX

**Clinic Location:**

FAS DPN Clinic  
Children's Village  
3801 Kern Road  
Yakima, WA 98902  
[JoAnn.Jennings@yvmh.org](mailto:JoAnn.Jennings@yvmh.org)

# Mental Health/ Substance Abuse Assessments

---

Eligible clients may go for a mental health or substance abuse assessment without an EPSDT screening or referral.

## Mental Health

Eligible clients should be screened for mental health problems as part of the EPSDT screening process. Mental Health screenings can be done using standardized screening tools or through an interview. See Page D.3 for EPSDT Mental Health/Substance Abuse Assessment Referral Indicators for a list of behaviors that may indicate mental health problems. Referral for assessment is based on professional judgement. See Page D.6, *Referral for Mental Health/Substance Abuse Assessment* for a sample of the referral form to be used for children needing a mental health assessment. The referral form should be sent to the appropriate assessment site and/or Regional Support Network (RSN).

### Screening Guidelines

Mental health and substance abuse screenings are intended to identify children who are at risk for, or may have, mental health or substance abuse problems. *Screenings do not result in a diagnosis. If a screen indicates a possible problem, the child is referred for an assessment where a diagnosis and plan of care are developed.*

Screenings for mental health or substance abuse problems in children can be done using standardized screening tools or through an interview. Referral is based on professional judgement.

When child abuse or neglect is suspected, a report to Child Protective Services must be made, even if the child is also referred for a mental health assessment.

If an eligible client is suspected or identified through the EPSDT screening as having a mental health or substance abuse problem, providers may refer the client to a mental health or substance abuse provider. Complete a **DSHS Referral for Mental Health/Substance Abuse Assessment** form [DSHS 01-192X] and assist the client/family in making appointments and obtaining necessary treatment(s). This referral must be made within two weeks from the date the problem is identified, unless the problem is urgent. If the problem is urgent, a referral must be made immediately.

Document the need for the service(s) in the client's records. The diagnosing or treating mental health or substance abuse provider should communicate the results of the referral back to the primary care provider.

### **Non-Urgent Referral**

When screening for mental health problems, use your professional judgement when deciding to refer the client for further assessment of other issues, such as:

- Family issues.
- Problematic peer activities.
- School issues.
- Somatic symptoms.
- Abnormal behaviors.
- Unusual feelings and thoughts.
- Unusual growth and development.
- Social situation problems.

Screening infants and toddlers for mental health problems is an emerging science. Use your professional judgement to determine if referral is appropriate when there are concerns that the family and social environment do not support the infant's mental wellness.

**Children should also be referred for a mental health assessment at a parent's request. If the child or parent sees the behavior or symptom as problematic, make a referral, even if the issues seem minor or within "normal" range to you. Parents' and teachers' perceptions have shown to be the best predictors of mental health problems.**

### **Urgent Referral**

Some behaviors or symptoms are significant enough to trigger an immediate referral with the mental health agency by telephone to describe the urgent nature of the referral. Behaviors/symptoms which require urgent referral include, but are not limited to:

- Fire-setting.
- Suicidal behavior or suicidal ideation.
- Self-destructive behavior.
- Torturing animals.
- Destroying property.
- Substance abuse in conjunction with other mental health concerns, or under the age of 12 years.
- Sexual acting out.
- Witnessing a death or other substantial physical violence.
- Victimization (sexual or physical abuse).
- Out of touch with reality, delusional (psychotic decompensation).
- Imminent risk of placement in a more restrictive setting.

The presence of any of these behaviors or symptoms may signal that a child is in crisis and efforts should be made to expedite the referral process so that the child may be assessed and treated promptly. The crisis response system should be used only if the child is a danger to himself/herself or others.

## Substance Abuse

The categories listed in the section titled *Substance Abuse Services* may be used to help screen for substance abuse problems in an interview. To refer substance abuse cases, call the 24-hour Alcohol/Drug Helpline at 1-800-562-1240.

The following questions may be used with adolescents to screen for abuse or addiction to alcohol and/or other drugs. These questions have been scientifically validated as part of a psychometric assessment tool. **A "yes" answer to any two questions is usually sufficient to warrant a referral for assessment.**

### **Substance Misuse Questions:**

1. Do more than half of the students you know drink alcoholic beverages or use other drugs at least once a month?
2. During your first experiences drinking alcohol or using other drugs, would a close friend have described you as sharing more of your feelings with them?
3. Have any of your early drinking or drug experiences made you feel less self-conscious in a group of people?

### **Substance Misuse and Abuse Question:**

4. Have you ever lied to people such as your parents, teachers, or nonusing friends about your alcohol or other drug use?

### **Substance Abuse Questions:**

5. Have you ever felt really burnt out for a day after using alcohol or other drugs?
6. Have your grades gone downhill as your use of alcohol or drugs went up?
7. Did you ever drink or get high in school?

### **Substance Addiction Questions:**

8. Do you often skip things you need to do so you can go drink or get high?
9. Have you stolen money to buy alcohol or drugs?
10. Has any of your family (including parents, step-parents, grandparents, brothers, sisters, etc.) had or had past problems with drinking or drug use?

The presence of any of the symptoms or behaviors listed under **Urgent Referrals** on the preceding page may signal that the child is in crisis. You may call the **24-hour Alcohol and Drug Help Line at 1-800-562-1240.**

## INFORMATION AND REFERRAL

### ALCOHOL/DRUG 24-HOUR HELP LINE

- **CRISIS LINE:** (206) 722-3700
- **TOLL FREE** 1-800-562-1240  
(from within Washington State only)
- **TEEN LINE** (206) 722-4222
- **BUSINESS LINE** (206) 722-3703

**Crisis Intervention...** Confidential statewide telephone service providing individual guidance and assistance for people with alcohol and other drug-related problems. It provides information on a wide variety of issues and services and assists with crisis intervention techniques and referral.

### WASHINGTON STATE ALCOHOL/DRUG CLEARINGHOUSE

3700 Rainier Avenue South, Suite A  
Seattle, WA 98144

E-Mail: [clearinghouse@adhl.org](mailto:clearinghouse@adhl.org)

Web site: <http://www.adhl.org/clearinghouse>

Liz Wilhelm, Clearinghouse Manager

- 1-800-662-9111 toll free (if calling from within Washington State)
- (206) 725-9696 (if calling from out of state, or from Seattle)
- (206) 722-1032 FAX

**Using the Clearinghouse...** Anyone is welcome to use services, including prevention and community organizations, parents, treatment professionals, preschool-through college students and educators, health care practitioners and hospitals, libraries, state and government agencies, business and individuals.

- Books • Posters • Pamphlets • Curricula •
- Journal and periodical articles • Videos •

**Visitors welcome.**

**We have a display available  
for  
community, school, and health fairs.**

**A Nationwide Network of Partners in Prevention.** Provides information to the public of Washington State from the national clearinghouse (NCADI) on issues relating to alcohol and other drugs. Member of the Regional Alcohol and Drug Awareness Resource (RADAR) Network of 50 states clearinghouses and specialty centers.

**What kind of information is available?** They provide a continually updated substance abuse resource room; information on programs, personnel and referral; networking; access to an indepth clipping file; hundreds of complimentary copies of printed materials.

**Also available are:**

- ✓ Directory of Certified Chemical Dependency Treatment Services in Washington State (The Greenbook)
- ✓ Chapter 388-805, Washington Administrative Code (WAC) (Chemical Dependency Service Providers)
- ✓ WAC Implementation Guide (WIG) for WAC 388-805
- ✓ Forms re-ordering for DASA-Certified DUI assessment facilities: DUI/PC Assessment Report forms.
- ✓ The Courts can re-order Alcohol/Drug Diagnostic Referral Forms (DSHS 9-630)
- ✓ Purchase of American Society of Addiction Medicine (ASAM) Patient Placement Criteria manuals.

**Referral for Mental Health/Substance Abuse Assessment  
DSHS Form 01-192X**

**Go to:**

<http://www.wa.gov/dshs/dshsforms/forms/eforms.html>

**to print form.**

**REORDER INFORMATION**

**DSHS 01-192X  
REFERRAL FOR MENTAL HEALTH/  
SUBSTANCE ABUSE ASSESSMENT**

If you need additional copies of this referral form, mail or fax a written request on letterhead to:

DSHS Warehouse  
PO Box 45816  
Olympia, WA 98504-5816  
FAX (360) 664-0597  
Telephone (360) 753-7057



**EPSDT MENTAL HEALTH/SUBSTANCE ABUSE  
ASSESSMENT REFERRAL INDICATORS**

**Consider these and other symptoms/behaviors when making a referral for an assessment.**

<b>Category</b>	<b>Indicators for a Mental Health Assessment</b>	
Family	problems separating physical abuse or neglect psychological abuse sexual abuse domestic violence divorce/separation chronic physical or mental illness of parent	drug using or alcoholic parent parental discord few social ties problems with siblings death of parent/sibling parents in criminal justice system
Peer activity	no confidence social isolation	fighting and bullying
Behaviors	temper tantrums fire setting stealing tics sexually acting out lying substance abuse destroys property aggressive	over activity in trouble with law impulsive attachment problems in infants overly compliant to passive defiant running away truancy
School	school failure school refusal	absenteeism or truancy
Feelings	anxiety or nervousness feeling depressed low self-esteem	fearful suicidal
Thoughts	delusions hallucinations	incoherence self-destructive thoughts
Somatic symptoms	trouble sleeping sleepwalking night terrors	enuresis encopresis eating disorder
Social	lack of housing frequent moves financial problems	sexual abuse foster care history of detention
Growth and Development	slow weight gain nonorganic failure to thrive mentally retarded learning disabilities	language delay attention problems speech problems

Derived from a World Health Organization, primary care child oriented classification system. Haeres, S.M., Leaf, P.J., Leventhal, J.M., Forsyth, B. and Speechley, K.N. (1992), Identification and management of psychosocial and developmental problems in community-based. Primary care pediatric practices. *Pediatrics*, 89(3), 480 - 485.

The indicators listed above may be elicited from caregivers and children through interviews described in professional references (e.g., American Academy of Pediatrics: Guidelines for Child Health Supervision; and the Region X Nursing Network: Prenatal and Child Health Screening and Assessment Manual). It may be appropriate to interview the child separate from the caregiver beginning at age eight years.

Screening infants and toddlers for mental health problems is an emerging science. Based on professional judgment, referral is appropriate when there are concerns that a family and social environment do not support the infant's mental wellness.

Children with behaviors not listed on the checklist should also be referred for mental health services, if the parent desires. It is important to remember that if the child or parent sees the behavior or symptom as problematic, make a referral, even if the issues seem minor or within "normal" range to you. Parents' and teachers' perceptions have been shown to be the best predictors of mental health problems.

# WA State Regional Support Networks (RSNs)

Current Information as of **May 1, 2001**

RSN	Telephone FAX	Crisis Lines 1-800 Access	Administrator <i>Email</i>
<b>Chelan-Douglas RSN</b> 636 Valley Mall Pkwy Ste 200 East Wenatchee, WA 98802-4875	<b>(509) 886-6318</b> (509) 886-6320	24h Crisis: 1-800-852-2923 RSN: 1-877-563-3678 RSN numbers TDD capable	Marty Driggs Administrator <a href="mailto:martydr@bdsn.com">martydr@bdsn.com</a>
<b>Clark County RSN</b> PO Box 5000 Vancouver, WA 98666-5000	<b>(360) 397-2130</b> <b>Ext. 7689</b> (360) 397-6028	24h Crisis: (360) 696-9560	Cheri Dolezal RSN Manager <a href="mailto:cheri.dolezal@co.clark.wa.us">cheri.dolezal@co.clark.wa.us</a>
<b>Grays Harbor RSN</b> 2109 Sumner Avenue Aberdeen, WA 98520-3699	<b>(360) 532-8665</b> (360) 533-1983	24h Crisis: 1-800-685-6556	Becky Kellas RSN Coordinator <a href="mailto:bkellas@co.grays-harbor.wa.us">bkellas@co.grays-harbor.wa.us</a>
<b>Greater Columbia Behavioral Health RSN</b> 101 N. Edison Street Kennewick, WA 99336-1958	<b>(509) 735-8681</b> (509) 783-4165	1-800-257-0660	Vic Roberts Coordinator <a href="mailto:gcrsn@gcbh.org">gcrsn@gcbh.org</a>
<b>King County RSN</b> Exchange Building 821 Second Avenue, Ste 610 Seattle, WA 98104-5019	<b>(206) 205-1332</b> (206) 296-0583	24h Crisis: 1-800-244-5756 Crisis Local: (206) 461-3222 UBH: 1-800-790-8049	Jackie Maclean Acting Administrator <a href="mailto:jackie.maclean@metrokc.gov">jackie.maclean@metrokc.gov</a>
<b>North Central WA RSN</b> 131 Basin Street SW Ephrata, WA 98823-1855	<b>(509) 754-6577</b> (509) 754-6580	RSN: 1-800-251-5350	Bill Hardy Administrator <a href="mailto:hardyb@bossiq.com">hardyb@bossiq.com</a>
<b>Northeast WA RSN</b> PO Box 1249 Chewelah, WA 99109-1249	<b>(509) 935-6801</b> <b>x17</b> (509) 935-4862	1-800-767-6081	Jackie Hurn Administrator <a href="mailto:jhurn@co.stevens.wa.us">jhurn@co.stevens.wa.us</a>
<b>North Sound RSN</b> 117 N 1ST Street, Ste #8 Mt. Vernon, WA 98273-2858	<b>(360) 416-7013</b> <b>x39</b> (360) 416-7017	24h Crisis: 1-800-584-3578 RSN: 1-800-684-3555	Chuck Benjamin Executive Director <a href="mailto:executivedirector@nsrsn.org">executivedirector@nsrsn.org</a>
<b>Peninsula RSN</b> 614 Division St., MS 23 Pt. Orchard, WA 98366-4676	<b>(360) 337-4886</b> (360) 337-5721	24h Crisis: 1-800-843-4793 RSN: 1-800-525-5637	Anders Edgerton Executive Director <a href="mailto:aedgertn@co.kitsap.wa.us">aedgertn@co.kitsap.wa.us</a>
<b>Pierce County</b> 215 S. 36th Street Tacoma, WA 98418	<b>(253) 798-4926</b> (253) 798-4470	24h Crisis: 1-800-576-7764	Fran Lewis RSN Manager <a href="mailto:flewis@co.pierce.wa.us">flewis@co.pierce.wa.us</a>
<b>Southwest RSN</b> 1952 9th Avenue Longview, WA 98632-4045	<b>(360) 414-5599</b> (360) 501-1207	24h Crisis: (360) 425-6064	Lesley Bombardier RSN Coordinator <a href="mailto:bombardierl@co.cowlitz.wa.us">bombardierl@co.cowlitz.wa.us</a>
<b>Spokane County RSN</b> Monroe Court Bldg. 901 N. Monroe Street, Ste 328 Spokane, WA 99201-2148	<b>(509) 477-4515</b> (509) 477-6204	24h Crisis: (509) 838-4428	Rafaela Ortiz RSN Program Manager <a href="mailto:rortiz@spokanecounty.org">rortiz@spokanecounty.org</a>
<b>Thurston-Mason RSN</b> 529 Fourth Avenue W Olympia, WA 98501-8210	<b>(360) 786-5585</b> <b>x7225</b> (360) 754-2988	24h Crisis: 1-800-624-1234	Mark Freedman RSN Manager <a href="mailto:freedmm@co.thurston.wa.us">freedmm@co.thurston.wa.us</a>
<b>Timberlands RSN</b> PO Box 217 Cathlamet, WA 98612-0217	<b>(360) 795-3118</b> (360) 795-3126	Lewis: 1-800-559-6696 Pacific: 1-800-884-2298 Wahkiakum: 1-800-635-5989	Gary Rose RSN Administrator <a href="mailto:roseg@co.wahkiakum.wa.us">roseg@co.wahkiakum.wa.us</a>

## **REFERRAL EXPLANATION FOR TEEN AND/OR PARENT**

### **SO YOU HAVE BEEN REFERRED FOR A MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT... NOW WHAT HAPPENS?**

**You and your health care provider have talked. The next step is to refer you for an assessment to find out if you need services.**

**A skilled worker will meet with you and may talk about several things such as:**

- \* What worries you or others about you?**
- \* What you and others have already done to help.**
- \* Relationships at home, at school, day care, with other friends, etc.**
- \* A family history.**
- \* How serious your problems may or may not be.**

**You and the worker will help choose the service that is right for you.**

**You may have questions. You may have problems in getting a Mental Health/Substance Abuse assessment. If you do, call the MAA Customer Service Center at 1-800-562-3022.**

**This is a blank page.**

# Billing

---

Bill for services such as laboratory work, hearing tests, x-rays, or immunization administration, using the appropriate procedure code(s), along with the screening (CPT codes 99381 - 99395) on the same HCFA-1500 claim form.

When physicians and ARNPs identify problems during a screening examination, they may treat the client or may refer the client to another provider. Physicians, and ARNPs are not limited to the procedure codes listed in MAA's EPSDT Billing Instructions. They may also use MAA's Physician-Related Services (RBRVS) Billing Instructions as necessary. Any office, laboratory, radiology, immunization, or other procedure rendered as part of follow-up treatment **must be billed** on a **SEPARATE** HCFA-1500 claim form from the screening examination.

## What is the time limit for billing? [Refer to WAC 388-502-0150]

- Providers must submit initial claims and adjust prior claims in a timely manner. MAA has two timelines standards: 1) for initial claims; and 2) for resubmitted claims.
- The provider must submit claims as described in MAA's billing instructions.
- Providers must submit their claim to MAA and have an Internal Control Number (ICN) assigned by MAA within 365 days from any of the following:
  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed<sup>1</sup> certification criteria.




**Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.

<sup>1</sup> **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill, demand, collect, or accept payment** from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

**Eligibility Established After Date of Service but Within the Same Month** - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill, demand, collect, or accept payment** from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
  - ✓ DSHS certification of a client for a retroactive<sup>2</sup> period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.
- MAA requires providers to bill third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.
- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.
 

 **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.
- The time periods do not apply to overpayments that the provider must refund to DSHS. After the time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

## How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager (PCCM) name in field 17 on the HCFA-1500 claim form; and
- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

**Note: Newborns of clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen for the newborn.**

<sup>2</sup> **Retroactive Certification** - According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill, demand, collect, or accept payment** from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

## Third party liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different than MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding *MAA Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA; and
- Attach the insurance carrier's statement.

If you are rebilling, also attach a copy of the *MAA Remittance and Status Report* showing the previous denial.

If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the **Comments** field of the Electronic Media Claim (EMC).

Third-party carrier codes are available via the Internet at <http://maa.dshs.wa.gov> or by calling the Coordination of Benefits Section at 1-800-562-6136.

# Fee Schedule

## EPSDT Screenings

*Note: Make certain the procedure code you use corresponds correctly to the age of the child receiving the EPSDT services.*

Use the PIC of either parent for a newborn if the baby has not yet been issued a PIC. Enter indicator **B** in *field 19* of the HCFA-1500 claim form to indicate that the baby is using a parent's PIC. When using a parent's PIC for twins or triplets, etc., identify each baby separately (i.e., twin A, twin B) using a *separate HCFA-1500 claim form* for each. **Note: The parents' Healthy Options Plan is responsible for providing medical coverage for the newborn.**

**Foster Care Children:** MAA reimburses appropriate providers an enhanced, flat fee of \$120.00 per EPSDT screen for foster care children. This applies to CPT™ codes 99381-99385 and 99391-99395 only. To receive the enhanced rate, providers must include modifier 21 in field 24D on the HCFA-1500 claim form to identify the child as a foster care child.

**Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT® procedure code descriptions. To view the full descriptions, refer to your current CPT® book.**

## New Patient

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee		
		NFS Fee	FS Fee	Foster Care
99381	Prev visit, new, infant	\$59.39	\$36.07	\$120.00
99382	Prev visit, new, age 1-4	68.60	44.42	120.00
99383	Prev visit, new, age 5-11	77.82	51.43	120.00
99384	Prev visit new, age 12-17	82.41	56.69	120.00
99385	Prev visit, new, age 18-20	87.01	59.85	120.00

## Established Patient

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee		
		NFS Fee	FS Fee	Foster Care
99391	Prev visit, est. infant	\$46.03	\$32.02	\$120.00
99392	Prev visit, est, age 1-4	55.25	39.77	120.00
99393	Prev visit, est, age 5-11	63.99	46.67	120.00
99394	Prev visit, est, age 12-17	68.60	51.59	120.00
99395	Prev visit, est, age 18-20	73.21	54.41	120.00

The appropriate diagnosis code is required when billing the above EPSDT screening CPT® codes 99381-99395.

#Memo 03-29 MAA

(Revised July 2003)

- E.4 -

Billing/Fee Schedule



## Interperiodic Screenings

Procedure Code/Mod	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
99201 – EP	Office/outpatient visit, new	\$33.84	\$22.08
99202 – EP	Office/outpatient visit, new	60.20	43.81
99203 – EP	Office/outpatient visit, new	89.05	66.97
99204 – EP	Office/outpatient visit, new	126.81	99.02
99205 – EP	Office/outpatient visit, new	161.71	131.79
99211 – EP	Office/outpatient visit, est	19.95	8.55
99212 – EP	Office/outpatient visit, est	35.26	22.08
99213 – EP	Office/outpatient visit, est	49.16	33.13
99214 – EP	Office/outpatient visit, est	76.94	54.14
99215 - EP	Office/outpatient visit, est	112.56	87.27

## Laboratory Services

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
36415	Drawing blood	\$2.45	\$2.45
81000	Urinalysis, nonauto w/scope	3.59	3.59
81001	Urinalysis, auto w/scope	3.59	3.59
81002	Urinalysis, nonauto w/o scope	2.89	2.89
81003	Urinalysis, auto, w/o scope	2.54	2.54
81005	Urinalysis	2.45	2.45
81007	Urine screen for bacteria	2.91	2.91
81015	Microscopic exam of urine	3.43	3.43
81025	Urine pregnancy test	4.25	4.25
81050	Urinalysis, volume measure	3.39	3.39
81099	Urinalysis test procedure	18.63	18.63
82135	Assay, aminolevulinic acid	13.70	13.70
83655	Assay of lead	2.38	2.38
84035	Assay of phenylketones	16.24	16.24
84202	Assay RBC protoporphyrin	9.74	9.74
84203	Test RBC protoporphyrin	2.68	2.68
85013	Hematocrit	2.68	2.68
85014	Hematocrit	2.68	2.68
85018	Hemoglobin	2.68	2.68
86580	TB intradermal test	6.14	6.14
86585	TB tine test	4.78	4.78

## Immunizations

The following procedure codes must be used to bill for the administration of immunizations:

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
90471	Immunization admin	\$5.00	\$5.00
90472	Immunization admin, each add	\$3.00	\$3.00

Immunizations for EPSDT are usually given in conjunction with a screening or interperiodic screening. Do not bill an Evaluation and Management (E&M) code unless there is a separate, identifiable diagnosis that is different from the immunization.

- MAA will reimburse an administration fee (up to \$5.00) for vaccines available through the state's Universal Vaccine Distribution program and the Federal Vaccines for Children program for children 18 years of age and under. When immunization materials are received from the Department of Health, you must bill the appropriate procedure code with **modifier –SL** (e.g., 90700-SL). **In the following list, the procedure codes that are shaded identify these vaccines. Do not bill CPT codes 90471 and 90472.**
- Do not bill with modifier -SL for any of the procedure codes listed on the following page if the client is 19 through 20 years of age, or if the procedure code is NOT shaded.
- Bill 90471 and 90472 with the vaccine or toxoid procedure code.
- Do not bill administration codes 90471 and 90472:
  - ✓ As multiple units; or
  - ✓ More than once per day, per client.
- Bill only CPT code 90471 when administering one vaccine. Bill both CPT codes 90471 and 90472 with one unit per code when administering more than one vaccine. MAA will reimburse a maximum of \$8.00 when:
  - ✓ More than one vaccine is administered; and,
  - ✓ Both CPT codes 90471 and 90472 are billed; and,
  - ✓ Those vaccines are not available through the Universal Vaccine Distribution Program or Federal Vaccines for Children Program.
- When an immunization is the only service performed, and the vaccine **is not** available free of charge from the Department of Health (DOH), the provider may bill a CPT immunization administration code in addition to the vaccine drug code. If the vaccine **is** available free of charge from DOH, the provider must bill MAA the vaccine drug code with the modifier –SL. MAA will reimburse the provider an administration fee.
- Reimbursement rates for immunization materials include federal excise tax.

## Immunization Fees

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
90476	Adenovirus vaccine, type 4	Not covered	Not covered
90477	Adenovirus vaccine , type 7	Not covered	Not covered
90581	Anthrax vaccine, sc	Not covered	Not covered
90585	Bcg vaccine, percut	\$144.96	\$144.96
90586	Bcg vaccine, intravesical	144.96	144.96
90632	Hep a vaccine, adult im	55.27	55.27
90633	Hep a vacc, ped/adol, 2 dose	26.98	26.98
90634	Hep a vacc, ped/adol, 3 dose	Not covered	Not covered
90636	Hep a/hep b vacc, adult im	84.41	84.41
90645	Hib vaccine, hboc, im	22.02	22.02
90646	Hib vaccine, prp-d, im	18.41	18.41
90647	Hib vaccine, prp-omp, im	15.90	15.90
90648	Hib vaccine, prp-t, im	20.84	20.84
90657	Flu vaccine, 6-35 mo, im	2.59	2.59
90658	Flu vaccine, 3 yrs, im	4.04	8.08
90659	Flu vaccine, whole, im	2.59	2.59
90660	Flu vaccine, nasal	Not covered	Not covered
90665	Lyme disease vaccine, im	55.31	55.31
90669	Pneumococcal vacc, ped<5	65.47	65.47
90675	Rabies vaccine, im	123.26	123.26
90676	Rabies vaccine, id	77.94	77.94
90680	Rotovirus vace, oral	Not covered	Not covered
90690	Typhoid vaccine, oral	9.21	9.21
90691	Typhoid vaccine, im	38.02	38.02
90692	Typhoid vaccine, h-p, sc/id	1.01	1.01
90693	Typhoid vaccine, akd, sc	Not covered	Not covered
90700	Dtap vaccine, im	20.29	20.29
90701	Dtp vaccine, im	9.52	9.52
90702	Dt vaccine <7, im	3.26	3.26
90703	Tetanus vaccine, im	7.79	7.79
90704	Mumps vaccine, sc	13.01	13.01
90705	Measles vaccine, sc	13.04	13.04
90706	Rubella vaccine, sc	15.15	15.15
90707	Mmr vaccine, sc	36.85	36.85
90708	Measles-rubella vaccine, sc	21.81	21.81
90710	Mmr v vaccine, sc	Not covered	Not covered
90712	Oral poliovirus vaccine	17.59	17.59

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
90713	Poliovirus, ipv, sc	\$23.27	\$23.27
90716	Chicken pox vaccine, sc	62.31	62.31
90717	Yellow fever vaccine, sc	53.56	53.56
90718	Td vaccine >7, im	10.43	10.43
90719	Diphtheria vaccine, im	Not covered	Not covered
90720	Dtp/hib vaccine, im	34.03	34.03
90721	Dtp/hib vaccine, im	Not covered	Not covered
90725	Cholera vaccine, injectable	2.78	2.78
90732	Pneumococcal vacc, adult/ill	11.86	11.86
90733	Meningococcal vaccine, sc	59.35	59.35
90735	Encephalitis vaccine, sc	72.20	72.20
90740	Hepb vacc, ill pat 3 dose im	100.41	100.41
90743	Heb b vacc, adol, 2 dose, im	24.49	24.49
90744	Hepb vacc ped/adol 3 dose, im	24.49	24.49
90746	Hep b vaccine, adult, im	50.21	50.21
90747	Hepb vacc, ill pat 4 dose, im	100.41	100.41
90748	Heb b/hib vaccine, im	92.02	92.02
90749	Vaccine toxoid	By Report	By Report

### Injectable Drugs (J-Codes)

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
J0850	Cytomegalovirus imm IV / vial	\$635.79	\$635.79
J1460	Gamma globulin 1 CC inj	10.32	10.32
J1470	Gamma globulin 2 CC inj	20.64	20.64
J1480	Gamma globulin 3 CC inj	31.00	31.00
J1490	Gamma globulin 4 CC inj	41.28	41.28
J1500	Gamma globulin 5 CC inj	51.60	51.60
J1510	Gamma globulin 6 CC inj	61.80	61.80
J1520	Gamma globulin 7 CC inj	72.17	72.17
J1530	Gamma globulin 8 CC inj	82.56	82.56
J1540	Gamma globulin 9 CC inj	92.97	96.12
J1550	Gamma globulin 10 CC inj	103.20	103.20
J1560	Gamma globulin > 10 CC inj (per cc)	10.32	10.32
J1563	IV immune globulin	70.95	70.95
J1564	Immune globulin 10 mg	0.78	0.78

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
J1565	RSV-ivig	\$14.98	\$14.98
J1670	Tetanus immune globulin inj	107.50	107.50
J2790	Rho d immune globulin inj	90.82	90.82
J2792	Rho(D) immune globulin h, sd	18.60	18.60
90780	IV infusion therapy, 1 hour	26.39	26.39
90781	IV infusion, additional hour	13.42	13.42
90782	Injection, sc, im	2.73	2.73
90783	Injection, ia	9.78	9.78
90784	Injection, iv	11.38	11.38

### Immune Globulins

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
90281	Human ig, im	Not covered	Not covered
90283	Human ig, iv	Not covered	Not covered
90287	Botulinum antitoxin	Not covered	Not covered
90288	Botulism ig, iv	Not covered	Not covered
90291	Cmv ig, iv	Not covered	Not covered
90296	Diphtheria antitoxin	Not covered	Not covered
90371	Hep b ig, im	\$143.18	\$143.18
90375	Rabies ig, im/sc	65.95	65.95
90376	Rabies ig, heat treated	70.71	70.71
90378	Rsv ig, im, 50 mg ( <b>Requires prior authorization</b> )	\$598.00	\$598.00
		970.00	970.00
	Rsv ig, im, 100 mg ( <b>Requires prior authorization</b> )	1,568.00	1,568.00
		1,940.00	1,940.00
	Rsv ig, im, 150 mg ( <b>Requires prior authorization</b> )		
	Rsv ig, im, 200 mg ( <b>Requires prior authorization</b> )		
90379	Rsv ig, iv	Not covered	Not covered
90384	Rh ig, full-dose, im	Not covered	Not covered
90385	Rh ig, minidose, im	Not covered	Not covered
90386	Rh ig, iv	Not covered	Not covered
90389	Tetanus ig, im	Not covered	Not covered
90393	Vaccina ig, im	Not covered	Not covered
90396	Varicella-zoster ig, im	95.68	95.68
90399	Immune globulin	Not covered	Not covered

## Audiologic Function Tests

The audiometric tests listed below imply the use of calibrated electronic equipment. Other hearing tests are considered part of the general otorhinolaryngologic services and are not billed separately.

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
92552	Pure tone audiometry, air	\$10.92	\$10.92
92553	Audiometry, air & bone	16.15	16.15

## Fluoride Varnish Applications

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee	
		NFS Fee	FS Fee
D1203	Topical fluor w/o prophylaxis	\$13.39	\$13.39

# How to Complete the HCFA-1500 Claim Form

---

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

**Important!**

## *Guidelines/Instructions:*

- Use only the original preprinted red and white HCFA-1500 claim forms (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

If you need preprinted red and white HCFA-1500 claim forms, call 1-800-562-6188.

- Do not use red ink pens (use black ink for the circled “XO” on crossover claims), highlighters, “post-it notes,” or stickers anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, “REBILL,” “TRACER,” or “SECOND SUBMISSION” on claim form.
- Use standard typewritten fonts that are 10 c.p.i (characters per inch). Do not mix character fonts on the same claim form. Do not use italics or script.
- Use upper case (capital letters) for all alpha characters.
- Use black printer ribbon, ink-jet, or laser printer cartridges. Make sure ink is not too light or faded.
- Ensure all the claim information is entirely contained within the proper field on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.
- Place only six detail lines on each claim form. MAA does not accept “continued” claim forms. If more than six detail lines are needed, use additional claim forms.
- Show the total amount for each claim form separately. Do not indicate the entire total (for all claims) on the last claim form; total each claim form.

**Field Description/Instructions for Completion**

1a. **Insured's I.D. No.:** Required.  
Enter the MAA alphanumeric Patient (client) Identification Code (PIC) exactly as shown on the client's monthly Medical Assistance Identification (MAID) card. The PIC consists of the client's:

- a) First and middle initials (a dash [-] *must* be used if the middle initial is not available)
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY)
- c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- d) An alpha or numeric character (tiebreaker)

*For example:*

- 1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- 2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name:** Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate:** Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address:** Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name:** When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

- 9a. Enter the other insured's policy or group number *and* his/her Social Security Number.
- 9b. Enter the other insured's date of birth.
- 9c. Enter the other insured's employer's name or school name.
- 9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

**Please note:** DSHS, Welfare, Provider Services, Healthy Kids, HO or Healthy Options First Steps, and Medicare, etc., are inappropriate entries for this field.

11. **Insured's Policy Group or FECA**



- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b><u>(Federal Employees Compensation Act) Number:</u></b> When applicable. This information applies to the insured person listed in <i>field 4</i>. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payer of last resort.</p> <p>11a. <b><u>Insured's Date of Birth:</u></b> When applicable, enter the insured's birthdate, if different from <i>field 3</i>.</p> <p>11b. <b><u>Employer's Name or School Name:</u></b> When applicable, enter the insured's employer's name or school name.</p> <p>11c. <b><u>Insurance Plan Name or Program Name:</u></b> When applicable, show the insurance plan or program name to identify the primary insurance involved. (<i>Note: This may or may not be associated with a group plan.</i>)</p> <p>21. <b><u>Diagnosis or Nature of Illness or Injury:</u></b> When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.</p> <p>22. <b><u>Medicaid Resubmission:</u></b> When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the <i>claim number</i> listed on the Remittance and Status Report.)</p> | <p>24. <b><u>Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form. Total each page separately.</u></b></p> <p>24A. <b><u>Date(s) of Service:</u></b> Required. Enter the "from" and "to" dates using a 6-digit or 8-digit date of service. (Example: 080801 or 08082001) <b>Please indicate the actual MCM billing date, not the entire month.</b></p> <p style="padding-left: 40px;"><b>Do not use slashes, dashes or hyphens to separate month, day year.</b></p> <p>24B. <b><u>Place of Service:</u></b> Required. Enter a <b>3</b> for the Place of Service.</p> <p>24C. <b><u>Type of Service:</u></b> Required. Enter a <b>3</b> for all services billed.</p> <p>24D. <b><u>Procedures, Services or Supplies CPT/HCPCS:</u></b> Required. Enter the appropriate procedure code from these billing instructions. Do not include data such as descriptions of procedure or diagnosis codes on detail lines – <b>list only the code.</b></p> <p>24E. <b><u>Diagnosis Code:</u></b> Required. Enter the appropriate ICD-9-CM diagnosis code.</p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>24F. <b><u>\$ Charges:</u></b> Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.</p> <p>24G. <b><u>Days or Units:</u></b> Required. Enter the correct number of units. Use only whole numbers, not fractions.</p> <p>25. <b><u>Federal Tax ID Number:</u></b> Leave this field blank.</p> <p>26. <b><u>Your Patient's Account No.:</u></b> Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading <i>Patient Account Number</i>.</p> <p>28. <b><u>Total Charge:</u></b> Required. Enter the total amount of billed charges. Do not use a dollar sign or decimal point.</p> <p>29. <b><u>Amount Paid:</u></b> If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in <i>field 10d</i>. Do not use a dollar sign or decimal point or put Medicare payment here.</p> | <p>30. <b><u>Balance Due:</u></b> Required. Enter dollar amount owing (equal to field 28 value minus field 29 value). Do not use a dollar sign or decimal point.</p> <p>33. <b><u>Physician's, Supplier's Billing Name, Address, Zip Code and Phone #:</u></b> Required. Put your <i>Name</i>, <i>Address</i>, and <i>Phone #</i> on all claim forms.</p> <p><b><u>GRP#:</u></b> Enter the DSHS provider number assigned to you by MAA.</p> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)			MEDICAID <input type="checkbox"/> (Medicaid #)			CHAMPUS <input type="checkbox"/> (Sponsor's SSN)			CHAMPVA <input type="checkbox"/> (VA File #)			GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>			FECA BLK LUNG (SSN) <input type="checkbox"/>			OTHER <input type="checkbox"/> (ID)			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE MM DD YY M F						4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)																	
CITY						STATE						8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>						CITY						STATE											
ZIP CODE						TELEPHONE (Include Area Code) ( )						Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>						ZIP CODE						TELEPHONE (INCLUDE AREA CODE) ( )											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. INSURED'S DATE OF BIRTH MM DD YY M F						a. INSURED'S DATE OF BIRTH MM DD YY M F																	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F												b. EMPLOYER'S NAME OR SCHOOL NAME						b. EMPLOYER'S NAME OR SCHOOL NAME																	
c. EMPLOYER'S NAME OR SCHOOL NAME												c. INSURANCE PLAN NAME OR PROGRAM NAME						c. INSURANCE PLAN NAME OR PROGRAM NAME																	
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____																		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____																	
14. DATE OF CURRENT: MM DD YY						ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE												17a. I.D. NUMBER OF REFERRING PHYSICIAN						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. RESERVED FOR LOCAL USE																		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)																		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																	
2. _____																		23. PRIOR AUTHORIZATION NUMBER																	
24. A DATE(S) OF SERVICE. From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																																			
1																																			
2																																			
3																																			
4																																			
5																																			
6																																			
25. FEDERAL TAX I.D. NUMBER SSN EIN						26. PATIENT'S ACCOUNT NO.						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO						28. \$ TOTAL CHARGE						29. \$ AMOUNT PAID						30. \$ BALANCE DUE					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  SIGNED _____ DATE _____												32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #  PIN# _____ GRP# _____																	